

## DEPARTMENTAL POLICY

<b>POLICY # 211</b>	<b>SUBJECT:</b> Root Cause Analysis
<b>EFFECTIVE DATE:</b> April 15, 2007	<b>PAGE</b> 1 of 5
<b>AUTHORIZED SIGNATURE:</b>	

### ROOT CAUSE ANALYSIS

#### I. PURPOSE

The Department of Services for Children, Youth and Their Families recognizes the importance of being a self-correcting agency with a constant focus on safety and quality of services. The purpose of this policy is to provide a process to identify underlying systemic issues that lead to the occurrence of a critical incident that if corrected could prevent similar incidents from occurring. It is the intent of this policy to ensure all incidents falling within the definition of a critical incident are reviewed and recommended for a Root Cause Analysis when potential system issues are identified.

#### II. POLICY

This policy requires a team of DSCYF representatives identified for their expertise in specific areas to complete a thorough review and analysis of the critical incident and the factors leading up to the incident; determine the root causes (if any); and make recommendations for system improvements. The Root Cause Analysis Report and all related materials are to be used for self evaluation; are not for public dissemination; and are distributed only to the Department Safety Council, Division Directors and the Cabinet Secretary of the Children's Department.

#### III. DEFINITIONS

- A. Critical Incident – An unexpected incident that involves the serious injury, hospitalization, death, or escape of a child active in the Department. The Department has adopted the following definitions of incidents to be reported:
- Child Death – The loss of life of any child who is active with the Department of Services for Children, Youth and Their Families, or has been active within 12 months preceding his or her death.
  - Hospitalizations – An emergency hospital admission of a child active with the Department in any 24 hour Department operated or contracted program and the admission is for unanticipated illness, physical injury, attempted suicide; or any hospital admission of an active child in which the hospital staff reports suspected abuse/neglect to the Division of Family Services.
  - Escape from a Level V Program – The unauthorized departure from any Level V DYRS program.
  - Institutional Abuse Resulting in Arrest – The arrest of an employee in a Department operated or contracted program on a charge stemming from institutional abuse.

- B. Safety Council – A DSCYF panel consisting of two representatives from each of the service divisions and the Office of Case Management. The panel is responsible for reviewing all critical incidents (and other cases upon request) and recommending which incidents warrant a Root Cause Analysis.
- C. Systems Improvement Plan - An action plan developed by the Division Director(s) of each Division providing services at the time of the incident. Each Improvement Plan is presented to the Secretary following completion of the RCA and is tracked by the Division(s) and the Department Safety Council.
- D. Root Cause Analysis – A systemic process that uses the information gathered during an investigation to determine if (and what) fundamental system deficiencies led to the incident.
- E. Internal Review – A review process completed by the Division(s) involved in an active case (or involved within the last 12 months in the instance of a child death) . The type and level of review is determined by the Division(s) and can include management review, team review, RCA, or other recognized continuous improvement tools such as Barrier Analysis.
- F. Causal Factors – The contributing causes of the critical incident under review.

#### **IV. PROCEDURES**

##### **A. Safety Council Review**

1. Critical incidents meeting Department definitions are reported immediately by the Division(s) to the Department Safety Council through the Critical Incident Data base. Each Division shall have a representative who reviews all reportable events for that division and enters directly into the database any event that meets the definition of a department critical incident. In addition to the Safety Council review of the incident, a Division involved in the critical incident may also conduct an internal review of the case to evaluate the role and performance of personnel assigned to the case. It is the Division's responsibility to take any appropriate personnel actions.
2. The Safety Council staff conducts a review of the critical incident to include a summary of the incident, the Division's response, an abbreviated event line, Department history of child and family, and the identification of potential problem areas related to the incident. This information is recorded on the 'Critical Incident Review & Decision for Root Cause Analysis Referral' form (see Attachment A).
3. The Department Safety Council shall conduct a thorough review of all reported critical incidents.
4. The Safety Council will make a determination to refer or not refer an incident to the Cabinet Secretary for a Root Cause Analysis following a review of each incident. The Safety Council's recommendation will be forwarded to the OCM Administrator for review.
5. The OCM Administrator will review Safety Council decisions and can remand them to the Council for further clarification and/or consideration if appropriate.

6. Following the OCM Administrator review and concurrence with the Council's determination that a critical incident is appropriate for a RCA, the Safety Council will send the completed 'Critical Incident Review & Decision for Root Cause Analysis Referral' form to the Secretary of the Department for approval. The referral will include recommendations for the composition of the RCA team. The following criteria should be considered to determine the composition of the team:
  - i. Staff from Department, including OCM staff and Safety Council Members, who will bring objectivity and expertise related to the incident--priority will be given to staff trained on RCA procedures
  - ii. Ethnic and cultural diversity
  - iii. Geographic location
  - iv. Staff from other agencies or professions should not serve on the team
  - v. Individuals who had direct involvement with the incident should not serve on the team
  - vi. The Safety Council will recommend a chairperson for each RCA team. The Cabinet Secretary will approve and appoint each RCA Team chairperson.
7. Reasons for not referring an incident for a RCA might include: death due to chronic medical conditions/illness; death due to acute medical illness/expected outcome; no known system issues could have prevented; or hospitalization where no abuse or neglect issues are present.
8. For incidents not referred for a RCA by the Safety Council, the council may recommend an internal review be completed by an individual Division.

#### **B. RCA Team Process**

1. OCM staff will be responsible for collecting all pertinent case information and distributing it to RCA team members no later than the first meeting.
2. OCM staff and the RCA Team Chairperson will coordinate the scheduling of the first RCA Team meeting.
3. The Secretary or designee will convene the first meeting of each team.
4. At the first meeting, the team shall review and sign a confidentiality form and develop a schedule for completing the review and preparing the report.
5. All meetings of the team shall be closed to the public. All comments and testimony concerning clients are confidential.
6. The RCA Team may request any records pertaining to the client as deemed appropriate to accomplish its task. This request may also include records of clients in the case who have received services from a private agency under a purchase of service or care agreements with the Department. All records must be accounted for and safe guarded. OCM staff will be responsible for providing requested information, arranging meetings and interviews, and ensuring that the process follows prescribed RCA procedures.
7. The RCA Team will review collected Department case files, records, and chronologies relevant to the incident.
8. The RCA Team may interview staff members involved in the case, staff members of private agencies who have a purchase of service or care agreement with the Department, and any other individuals who have direct involvement in, or knowledge of the case, as appropriate.
9. The RCA Team will complete the Root Cause Analysis process and determine if root causes can be identified.

10. The RCA Team shall prepare a written report within 30 calendar days (from the date of the initial team meeting). The Chairperson may request additional time if needed by submitting a request to the Chair of the Department Safety Council.

11. The contents of the RCA Report may include the following:

- Incident description
- Facts and analysis
- Causal factors
- Conclusions which may include root causes
- Risk reduction strategies
- Recommendations for improvement(s) relating to the critical incident
- Appendices

The report shall not include recommendations concerning disciplinary actions against any employee.

12. Copies of the report will be submitted to the Secretary, Directors of Divisions involved with the incident, and the Department Safety Council.

### **C. Action Steps following the Root Cause Analysis Process**

1. Upon completion of the RCA Report, the Department Safety Council will review the report no later than the council's next scheduled meeting.
2. The RCA Team Chairperson presents the RCA Report to the Safety Council and participates in the Safety Council review and discussion.
3. The Safety Council completes a review prepares a written response to the report. The response may include suggested revisions or additional recommendations.
4. A meeting is scheduled with the Cabinet Secretary, Directors of Divisions involved with the incident, OCM Administrator or designee, Chair of the Safety Council, and the RCA Team Chairperson. The RCA Chair will present the report and answer questions of participants. The Chair of the Safety Council will present any recommendations of the Safety Council.
5. Within 30 calendar days of the meeting with the Cabinet Secretary, Division(s) will provide a Systems Improvement Plan to the Secretary and the OCM Administrator.
6. Upon approval of the Secretary, the involved Division(s) will begin executing the Systems Improvement Plan(s). It is the responsibility of the involved Division(s) to disseminate the information from the Root Cause Analysis and the Systems Improvement Plan to Department staff as appropriate. The RCA Chairperson should serve as a consultant to assist in getting the recommendations completed/implemented in their division, program, unit or facility.
7. The Department Safety Council will maintain a database to track the number of RCA assignments, critical incident types, system improvement recommendations to be accomplished, and timeframes for completion.
8. The Department Safety Council will monitor System Improvement Plan activities until completed.
9. The Department Safety Council will present Critical Incident and RCA Report aggregate data to Department Leadership in an annual report. Division Directors will disseminate information to their respective staff as appropriate.

**V. CONFIDENTIALITY**

- A. In carrying out this policy, the members of the RCA Team and department staff must ensure and protect the confidentiality of records and persons involved with the incident in accordance with applicable federal and state laws, the Department's policy on confidentiality and the Health Insurance Portability and Accountability Act (HIPAA).
- B. The RCA Reports and System Improvement Plans are kept in locked files in the Office of Case Management, are not part of the client case record, and shall not be used for any purpose not stated in this policy.
- C. A confidentiality sheet shall be signed by each RCA Team member stating that all documents (original and produced) and all verbal information shared shall be confidential and shall not be released to any person outside of the RCA Team.
- D. All documents are collected by OCM staff upon completion of the process.

**VI. IMPLEMENTATION**

- A. Any part of this policy which is in conflict with Federal or State laws shall be null and void; all other parts shall remain operative.

**Department Safety Council (DSC)**

**CRITICAL INCIDENT REVIEW  
&  
DECISION FOR ROOT CAUSE ANALYSIS REFERRAL**

**Case Information**

Name:  
DOB:  
PID:  
Incident Number:  
Incident Type:  
Incident Date:  
Date Reported:  
Division:  
OCM Report Writer:

**Critical Incident as Reported by Division to DSC:**

**OCM Summary of Critical Incident, Including Information Sources**

**DSC Critical Incident Definition Review:**

**Definitions of Critical Incidents**

**I. CHILD DEATHS:**

The loss of life of any child who is active with the Department of Services for Children, Youth and Their Families, or has been active within 12 months preceding his or her death.

**II. HOSPITALIZATIONS:**

An emergency hospital admission of a child active with the Department in any 24 hour Department operated or contracted program for which the admission is for unanticipated illness, physical injury or attempted suicide; or any hospital admission of an active child in which the hospital staff reports suspected abuse/neglect to the Division of Family Services.

**III. ESCAPE FROM A LEVEL V PROGRAM:**

The unauthorized departure from any Level V DYRS program.

**IV. INSTITUTIONAL ABUSE RESULTING IN ARREST:**

The arrest of an employee or provider in a Department operated or contracted program on a charge stemming from institutional abuse.

**Rationale for Accepting Incident:**

**DSC Decision re: Accepting Report as a Critical Incident:**

YES:  
NO:  
DATE:

**CONFIDENTIAL**

This report is the property of DSCYF and is for your information only and is not to be released or shared.

**DSCYF Policy #211--Attachment A**

**Summary of the Department's Immediate Response to the Incident:**

**Abbreviated Event Line of Critical Incident:**

**Identification of Potential Practice Problems Related to This Incident:**

**History of the Department's Involvement With This Child/Family:**

**DSC Recommendations for RCA or Other Review:**

Documentation of DSC Review and Decision, Including Discussion Dates:

Decision Date:

Further Review Recommended?

NO:

YES:

Type of Review:

**Recommendation to Cabinet Secretary for Appointment of a RCA Team**

Incident/Case Features	Competencies Preferred	Recommended Appointment
RCA Staff Person		

T=Trained in RCA, N=Not Trained, E=Prior RCA Team Experience

**CONFIDENTIAL**

This report is the property of DSCYF and is for your information only and is not to be released or shared.